RESEARCH HIGHLIGHTS

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HOUSING OPTIONS FOR ELDERLY OR CHRONICALLY ILL SHELTER USERS

Introduction

This research, conducted in 2002 and 2003 for Canada Mortgage and Housing Corporation (CMHC) by Luba Serge, a housing consultant, and Nancy Gnaedinger, a gerontology consultant, looked at:

- why some elderly and chronically ill people are living in homeless shelters,
- the barriers to other, more suitable housing options and
- some initiatives that have been undertaken to address the needs of this population.

When Canadian health care and shelter providers are asked which supports are most important for elderly or chronically ill homeless people, supervised housing tops the list. It should be subsidized, be accessible to people with mobility impairments and include a meal program and other support services as needed. The second most mentioned item is long-term residential care for people requiring 24-hour nursing care. Between supportive housing at one end and palliative care at the other, there needs to be a continuum of care offering different types and levels of support.

Methodology

The research involved a literature review, in-depth interviews with 20 key informants and the documentation of initiatives that respond to the needs of elderly and chronically ill shelter users. The interviews were carried out with long-term care providers, placement co-ordination service providers, emergency shelter providers and long-term care providers within the emergency shelter system. The interviews and the case studies were limited to five regions of Canada: Quebec, Ontario, Manitoba, British Columbia and Yukon.

Findings

Elderly and chronically ill shelter users

There is a growing consensus that "elderly" among the homeless population refers to persons aged 50 and over. Homelessness results in premature aging, with those at 50 looking and acting 10 to 20 years older. Stress, nutritional problems and untreated health conditions contribute to premature aging, and life expectancy is much lower than for people who are not homeless. There are even some homeless people younger than 50 who have the physical characteristics of a much older person, such as poor liver function and vitamin and calcium deficiencies.

People aged 50 and over represent about 20 to 30 per cent of shelter users in the locations studied, and there are indications that the size of this group is increasing. Elderly users tend to stay in shelters longer than those under age 50.

Many of the problems confronted by older homeless persons – such as alcoholism, mental illness, poor physical health and addictions – are no different from those of homeless people of all ages. Older shelter users, however, are more likely to suffer from dementia, stroke, heart conditions and incontinence. Drug addiction is expected to be an increasing issue, along with increases in Hepatitis C, HIV/AIDS and brain damage due to sniffing solvents.

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Chronically ill homeless people have particular difficulties, due to a lack of preventative care or early medical attention. For example, homeless persons with diabetes may neglect problems such as ulcers until they become very serious, develop into gangrene and perhaps require amputation.

Shelters, residential care and other options

While some shelters provide a few beds for persons needing bed rest, most cannot accommodate clients who are unable to attend to their own daily living needs, such as personal care. The shelters have neither sufficient staff nor the expertise to provide personal care, and it is not always possible to arrange home care services for shelter users. Physical accessibility is another problem. Some shelters, especially older ones, are not designed for persons with mobility impairments.

Still, hospitals are putting pressure on shelters to fill the gap in convalescent care. More and more homeless people who are too sick or too weak to return to their previous accommodation (for example, single room occupancy hotels, friends' couches or the street) are being discharged from hospitals to shelters. Because this is not an appropriate care strategy, some shelters have developed criteria for refusing referrals from hospitals.

Access to long-term residential care, or nursing homes, is limited in Canada due to an insufficient number of beds and funding resources. In fact, provincial funding for residential care has been so restricted in some jurisdictions in recent years that only those with very complex needs are placed. For example, in BC, only those who are assessed as being at "intolerable risk" and needing 24-hour nursing care are placed on a waiting list for residential care.

The policy in provinces where access to residential care has been severely restricted is that care will be delivered by community-based agencies to clients in their homes. Unfortunately, service providers advise that community-based care cannot meet the increasing volume and acuity of need in the community, due to limited financial and human resources.

However, mainstream residential care is not always the answer. Excessive use of alcohol by elderly or chronically ill homeless persons, heavy smoking, poor hygiene, poor housekeeping skills and anti-social behaviour (such as using foul language) can make it difficult to integrate them into residential care. Homeless people who are placed in mainstream care can find themselves ostracized for their behaviour.

Some shelter users, though, have moved into mainstream facilities with success. In Toronto, for example, some very frail women moved into long-term care, although they may still visit a shelter for social contact. In Montréal and Winnipeg, some previously homeless persons have successfully moved into mainstream residences, while others have found such facilities too restrictive or lonely and have left. Integrating homeless people into mainstream facilities probably works best for those who have not been homeless for long.

Supportive housing and assisted living have emerged as two options attempting to fill the gap. Both typically take the form of congregate housing with support services, but not 24-hour nursing care. Transitional housing and boarding houses are two other options, although some boarding houses have been found to exploit fragile and vulnerable tenants. Nonetheless, provision of subsidized supportive living spaces has not been able to match demand.

Elderly and chronically ill homeless persons require various services, but coordinating delivery poses a challenge. Of the five regions surveyed, coordination appears to be most established in Quebec. Quebec's Community Health and Social Services Centres (CLSCs) form a network of multi-service, multi-disciplinary teams. Contact between shelters and CLSCs facilitates the delivery of services to homeless persons and connects these clients with medical and social services.

The ideal residential facility

According to many of those interviewed, the ideal residential facility for elderly and chronically ill homeless people has less to do with the building and more to do with validating them as human beings, respecting their dignity and supporting them with a range of care options.

There are mixed opinions about the ideal location of a care facility for homeless people. Generally, the downtown area is preferred, provided the facility is not in a drug area or where residents are likely to be subject to predators. Downtown areas are familiar to residents and close to services such as day care centres, government-funded cafeterias and medical facilities. Alternatively, some informants suggested that a location in the outskirts of a city or in the country would be more appropriate, as it is away from predators.

Accommodation should be fully accessible and could include private and semi-private rooms, or a lockable room with a two-piece bath and small kitchenette. There should be communal rooms for dining and social events, case rooms where home nurses can do their work

and bathrooms where workers can help residents with bathing. The scale should be small, with 30 to 50 units per project at the most. Men and women should not be segregated into separate buildings but, where possible, people with like needs – for example, those with brain injuries or alcohol abuse problems – should be clustered together to facilitate delivery of services.
Services should be based on a holistic approach and include financial administration, health services, support services (such as meals and escorts to doctors' appointments) and social and recreational activities. Residents who are able should participate in running the home. There needs to be some form of full-time, on-site supervision. However, not all care staff and on-site services would be required 24 hours a day. In many cases, 12-hour on-site services would be sufficient.
Key staff members should include a lifeskills coach, a licensed practical nurse, a recreation aide, a social worker, personal care workers and cleaning workers. In the projects studied, staff typically had backgrounds in nursing, psychiatry, addictions, housing services, social work and the clergy.

The underlying philosophy, reflected in all the case studies, should be client-centred, with respect for people's humanity and adulthood uppermost. Emphasis should be given to healthy aging, harm reduction, individualized approaches to support and care, and abilities rather than to disabilities. There must be a lack of judgement on behaviour. Tolerance of alcohol misuse, certain behaviours and poor personal hygiene is clearly evident in the case studies.

Case studies: Meeting housing and care needs

Each case study in the research report describes the setting and services offered, the history behind the initiative, concerns and challenges, lessons learned and successes. All reflect principles of comprehensiveness of care, collaboration among many service providers, community involvement and support, and harm reduction.

Résidence du Vieux Port, Montréal
The Résidence du Vieux Port, opened in 1987, provides rooms for homeless men 50 years and older with alcohol or mental health problems. It is operated by Maison du Père, which has offered shelter and services to homeless men in downtown Montréal for over 30 years and has 132 rooms in its emergency shelter. The Résidence is relocating to the Maison property, which will increase the Résidence's capacity from 40 rooms to 72.

The decision to merge the Résidence with Maison du Père is in part propelled by economies of scale related to laundry, food preparation and maintenance. However, the move has raised concerns about being close to downtown bars, video lottery machines and those who prey on vulnerable persons. To protect older clients from younger predatory shelter users, the Résidence units will be separate from the shelter. While dining facilities will be shared, the two groups will eat in separate shifts. The impact of a planned common access area and a shared courtyard will be monitored.

Maison Claire Ménard, Montréal
Maison Claire Ménard offers permanent housing to homeless men 50 years and over. It has 31 self-contained units, including one for the janitor who handles emergencies and works closely with other team members. As much as possible, the men are supported in independent living, and three of the Maison's nine-member board are residents. The project has successfully increased the independence and stability of the residents, with few moving out.

Hospice for the Homeless, The Mission, Ottawa
The Mission, established in 1906, opened a 14-bed Hospice for the Homeless in May 2001. The Hospice is the only project in Canada dedicated exclusively to 24-hour palliative care for homeless men and women, or those at risk of becoming homeless. The average length of stay is about 100 days. Some clients are discharged or transferred, but most die at the Hospice.

Ottawa's Inner City Health Project provides and coordinates services, including convalescence, short-term and palliative care. The Project includes representatives from shelters and services for homeless persons, inner city primary health care facilities, a homecare organization, the City of Ottawa, the University of Ottawa and the Ottawa Hospital. The World Health Organization has recognized the Inner City Health Project and the Hospice with an Innovative Project Award.

Seaton House, St. Michael's Hospital and partners, Toronto
Seaton House, an inner city neighbourhood emergency shelter since 1934, also provides long-term shelter for up to 140 men who are over 50 and for younger men with serious health problems. Two of the case studies highlight integrated care approaches undertaken by Seaton House in partnership with St. Michael's Hospital, the University of Toronto and other partners, such as the Rotary Club of Toronto.

A new Infirmary service provides an additional 35 beds with 24-hour staff. The Infirmary cares for men with uncontrolled diabetes, pneumonia, schizophrenia, liver disease, cellulitis, cancer and severe depression. Palliative

care is available when needed. St. Michael's Rotary Transition Centre, located in the hospital's Emergency Department, is another collaborative initiative offering a place of respite for homeless persons where they can receive medical attention, shower, eat and have their clothes washed.

Birchmount Residence, Toronto

In 1999, Seaton House moved a large group of older men who were "going nowhere" to Birchmount Residence, a former nursing home with 60 beds. The men had been prone to victimization by younger shelter users. Most have some basic hygiene problems, and some have mobility problems, acute mental and/or physical health problems, and cognitive and developmental issues. About half have a substance abuse problem, usually alcohol.

The greatest challenge was overcoming the negative reaction of middle and upper middle class neighbours and their perception that children were at risk. A Community Reference Board, made up of 12 to 15 residents, service providers, community resource people, councillors and staff was established. This group was instrumental in overcoming community resistance and continues to meet. Community support has evolved to include donations of clothing, furniture and books. A neighbourhood volunteer committee visits residents and attends picnics and outings.

Transitional Housing Project for Aboriginal People with Mobility Disabilities, Winnipeg

This proposed project will provide transitional housing to homeless Aboriginal people who have a significant mobility disability (primarily spinal cord injury). While a site had not been selected at the time of the research, it is intended that the project be near shopping, transportation, medical services, schools and professional services. The facility will accommodate both individuals and, if needed, their immediate families.

The programming will offer peer support and the use of a holistic and traditional healing model. This will include spiritual and emotional counselling, collective healing ceremonies, 24-hour attendant care, and physical and occupational therapy. Other services will include addictions counselling, and lifeskills and money management training. Outreach will help coordinate services for those ready to move into permanent housing or for clients not residing in the facility.

Legion Wing, Prince George, B.C.

The Legion Wing is a two-storey apartment building adjacent to a residential care facility and directly above a seniors' centre. Located in a semi-residential neighbourhood with schools and parks, it is two blocks from a shopping mall and has a bus stop at the front door. There are 22 furnished housekeeping rooms, each with a kitchenette and a two-piece bathroom.

Services are client centred and based on a multi-disciplinary, harm-reduction approach. Several individuals with reputations for public drunkenness have been rehabilitated to become accepted members of their seniors' community. Some have even been reunited with estranged families. As well, financial abuse of this vulnerable population has been averted and reduced.

Hazelton Residence, Vancouver

Hazelton Residence is located in the Downtown Eastside of Vancouver, the "dumping ground for the hard-to-house and mentally ill in BC". In addition to an emergency shelter for 42 people, there are 39 rooms for elderly or chronically ill homeless persons. Balancing shelter and long-term care in the same building poses a challenge: emergency shelter users, typically younger people who are drug abusers, prey on the more vulnerable, long-term residents.

Most of the 39 residents are male. The majority have mental illness, alcohol and drug abuse problems, plus physical illnesses related to "living rough" and, in some cases, AIDS. Over the last 10 years, there have been more tenants with AIDS, Hepatitis C, dementias and mental illness.

On-site services include financial management, medications management, escorts to appointments, crisis intervention, referrals, advocacy and liaison to other providers. Visiting service providers include a doctor who visits twice weekly, home nursing, psychiatrists and mental health workers, and home support services. Physical therapy, podiatry and nutrition assessments are conducted as needed. Nearby services include a downtown health clinic and a community cafeteria two buildings away.

Veterans' Memorial Manor, Vancouver

Veterans' Memorial Manor is also located in the Downtown Eastside of Vancouver. A 1984-85 survey conducted by the federal Department of Veterans' Affairs revealed that over 900 veterans were living in very rundown conditions or on the street in the downtown core. This prompted the Department, service clubs, CMHC, the War Amps and the municipality to work together in developing the Manor.

Residents are males, and applicants must be aged 55 and over. The Manor provides safe, secure shelter along with access to inexpensive meals and medical and nursing care. Several residents have stopped misusing alcohol and have

been able to move from the Manor into regular social housing for seniors.

Former Integrated Program, Oak Bay Lodge, Victoria
Oak Bay Lodge, formerly a hotel, is located near an upscale residential area. There are 282 beds, and all residents require complex care. Most are frail, elderly females aged 85 and over who have multiple problems, including cognitive impairment. The Lodge offers 24-hour nursing care, meals on-site and other supports typical of residential long-term care.

In 1989, three beds in the facility were dedicated for use by clients of VISTA, an outreach program serving older adults with alcohol abuse and other addiction problems. These clients needed structure, rest, nourishment and attention to chronic and progressive disorders. After 12 years, the program was cancelled in 2002 for numerous reasons, such as increasing caseload pressures and changes in the facility's management and front line staff.

Fairway Woods, Victoria
Fairway Woods is a four-storey building being built in a suburban semi-residential area. It is on the same property as an extended care home, a dementia care home and a day centre for seniors. Residents will be seniors who have multiple health problems, such as mental illness, addictions, poor nutrition and physical ailments. Many will lack self-care skills and social supports, and will have been chronically homeless or have lived in substandard downtown hotels.

Fairway Woods will have 32 one-bedroom apartments, with eight designed for persons with disabilities, and activity areas on each floor, a communal dining room, an outdoor patio surrounded by trees, and a protected front porch.

Pioneer Inn, Whitehorse
In the mid-1980s, the manager of the Pioneer Inn recognized the advantage of renting under-utilized hotel rooms during low season to local people who might otherwise perish in their cabins, trailers or the street during the severe winters. The arrangement provided cash flow for the hotel during winter months and suitable housing for homeless and poorly housed people. The services have grown since then.

Up to 18 of the hotel's 30 rooms are for long-term tenancy by older adults who are homeless or hard to house. All rooms have a full bathroom and furniture, and 12 have a kitchenette. Tenants, who are mostly male, have multiple health problems, including arthritis, heart condition, diabetes and cardiovascular disease. More than half have problems related to alcohol addiction. Several have predatory "friends" who financially abuse them.

The hotel provides weekly housekeeping services, and the manager and her family offer many other services. These include daily room checks, free coffee and laundry soap, reminders regarding medications, escort to appointments including the hospital, grocery shopping, help with reading mail and prescriptions, and some meals.

Conclusions and recommendations

Shelters, transitional housing, boarding houses and most mainstream long-term care facilities are insufficient for meeting the needs of elderly and chronically ill homeless people. These facilities and their services were not designed to provide long-term housing nor do they have sufficient resources to provide the necessary care and supervision. The need for integrated health and social support services will only escalate in the future. An aging population, the challenges of meeting the needs of the homelessness population in general, and increasingly complex and serious health problems among homeless people all point to the need for a more systematic and integrated approach to providing health, residential and social services.

Relatively little research has been done on elderly or chronically ill homeless people, probably in part because they are a small portion of the entire homeless population. While the case studies identify some successful interventions, the report suggests further research related to this exploratory study:

- The means by which Birchmount Residence overcame community resistance, i.e. the NIMBY (not-in-my-back-yard) syndrome, should be documented more fully, and the successful strategies shared.
- Most facilities are larger than what was generally agreed to be the ideal size of 30 to 50 clients. The comparative financial viability of projects ranging in size should be assessed.
- Various ways of separating and protecting vulnerable shelter residents from potential predators should be documented.
- Research is needed on meeting the needs of elderly homeless women.
- Community development approaches for providing suitable housing options versus planned, policy-driven approaches should be compared and learned from.
- Recreational and leisure opportunities should be assessed for their effectiveness in helping to meet the needs of elderly or chronically ill residents.
- Research should be undertaken on how homeless persons and mainstream residential facilities adjust to each other.

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Research Report: *Housing Options for Elderly or Chronically Ill Shelter Users*

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Research Highlight: Communication Dynamics

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